ATTACHMENT VI - INSTRUCTIONS FOR COMPLETING "CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION"

ATTACHMENT VI

INSTRUCTIONS FOR COMPLETING
"CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION"

1. Date of Service: The date the abortion was performed. This can be typed or handwritten.

2. Patient's Full Name: The name of the Mother can be typed or handwritten.

3. Patient's Social Security Number: Mother's Social Security Number can be typed or handwritten.

4. Condition: Mark the block indicating the applicable reason for the abortion. This can be typed or handwritten.

5. Supporting Documentation: Mark the block that applies to the type of supporting documentation. This can be typed or handwritten.

6. Patient Address: Patient's complete address. This can be typed or handwritten.

7. Physician Signature: The physician must sign his/her name in his/her own handwriting.

8. Physician Name, Social Security Number and Address: The physician's name, Social Security Number and complete address. This can be typed or handwritten.

ATTACHMENT VI

CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION

DATE OF SERVICE: _____1_____

Based on my professional judgment, I certify that an abortion is medically necessary in the case of:

Patients' Full Name: _____**2**_____

Patients' Social Security Number: __ __ __ - __**3**__ - __ __ __ __

for the following reason:

(CHECK ONE) **4**

( ) There is credible evidence to believe the pregnancy is the result of rape or incest.

( ) The abortion is medically necessary as the woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

SUPPORTING DOCUMENTATION: **5**

(PLEASE CHECK THOSE THAT APPLY AND ATTACH DOCUMENTS)

( ) Documentation from a law enforcement agency indicating the patient has made a credible report as the victim of incest or rape.

( ) Documentation from a public health agency, Department of Human Services or Counseling agency (such as a Rape Crisis Center) indicating the patient has made a credible report as the victim of incest or rape.

( ) Medical records documenting the life saving nature of the abortion.

( ) Other (Please Specify): _____

PATIENT ADDRESS: **PHYSICIAN PERFORMING ABORTION:**

_____**6**_____
_____
_____

SIGNATURE: _____**7**_____
PHY. NAME: _____**8**_____
PHY. SS#: __ __ __-__ __-__ __ __ __
PHY. ADD.: _____
_____
_____
_____

ATTACHMENT VI

CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION

DATE OF SERVICE: _____

Based on my professional judgment, I certify that an abortion is medically necessary in the case of:

Patients' Full Name: _____

Patients' Social Security Number: __ __ __ - __ __ - __ __ __ __

for the following reason:

(CHECK ONE)

( ) There is credible evidence to believe the pregnancy is the result of rape or incest.

( ) The abortion is medically necessary as the woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

SUPPORTING DOCUMENTATION:

(PLEASE CHECK THOSE THAT APPLY AND ATTACH DOCUMENTS)

( ) Documentation from a law enforcement agency indicating the patient has made a credible report as the victim of incest or rape.

( ) Documentation from a public health agency, Department of Human Services or Counseling agency (such as a Rape Crisis Center) indicating the patient has made a credible report as the victim of incest or rape.

( ) Medical records documenting the life saving nature of the abortion.

( ) Other (Please Specify): _____

PATIENT ADDRESS:

_____
_____
_____

PHYSICIAN PERFORMING ABORTION:

SIGNATURE: _____
PHY. NAME: _____
PHY. SS#: __ __ __-__ __-__ __ __ __
PHY. ADD.: _____
_____
_____
_____

THIS FORM MAY BE DUPLICATED